No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29553

FILED SEP 2 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7861

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County: aaa

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4425 Tholozan Ave., 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 15

If yes, name country

3. (a) PRINT FULL NAME EDWARD STEDINGK

3. (b) If veteran, name war ---

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 10 (Month) (Day) 1879 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	8	7	hr. min.

9. Birthplace Red Bud (City, town, or county) Illinois 1 (State or foreign country)

10. Usual occupation Porter

11. Industry or business Tavern

FATHER
12. Name Charles Stedingk
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Emilia Schrieber
15. Birthplace Belleville, Illinois 1 (City, town, or county) (State or foreign country)

16. (a) Informant Otto Stedingk
(b) Address 4425 Tholozan Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation St. Trinity Cemetery

18. (a) Signature of funeral director Beiderwieden Funeral Home
(b) Address 1936 St. Louis Av.

19. (a) AUG 19 1947 (Date received local registrar) (b) J. F. Brederick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17
year 1947 hour 7 minute 15 A. M.

21. I hereby certify that I attended the deceased from Oct 26, 1944, to Aug 14, 1947, that I last saw him alive on August 14, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Appoplexy	instant
Due to Hypertension	10/26/44
Due to Nephritis	10/26/44
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature John A. Cornell (M. D. or other) MD

Address 5005 S. Grovers Date signed 8-18-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No.....,

working under my personal supervision.

Signed.....Neal L. Paulson.....

Licensed Embalmer No.....4114.....

P. O. Address 1936 St. Louis Ave.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.